J Cross Cult Gerontol (2016) 31:327–336
DOI 10.1007/s10823-016-9291-3

Institutional Context of Family Eldercare in Mexico and the United States

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Published online: 30 May 2016

Introduction

Mexico and the United States share a border over 2000 miles long and they also share the reality of rapidly aging populations. In each country the aging of the population is occurring in the context of very different levels of economic development and distinct political, cultural and institutional histories. The United States has a relatively long experience with long-term institutional and community care, while Mexico does not (Angel et al. 2012). For Mexico, limited fiscal resources and the needs of a large low-income population limit the possibilities (Gutiérrez et al. 2015). In both the United States and Mexico other options in addition to government sponsored programs must be developed.

In Mexico, as in nearly all other countries, the family remains the major source of support for most aging parents (Gomes and Montes de Oca 2004). For Latinos in the United States, the reliance on family has also been the norm (Wallace 2012). In the United States Social Security and Medicaid provide older Latinos a more adequate long-term safety net than is

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available to the elderly in Mexico, despite recent expansion in that country of social pensions and health care access (Angel and Angel 2015). The U.S. is far wealthier than Mexico and has a far more developed old-age support system. Even so, Latinos in the U.S. do not benefit fully from these programs and in many ways resemble the elderly in Mexico (Herrera et al. 2011).

In this *Brief Report*, we summarize the results of the latest version of the International Conference on Aging in the Americas (ICAA). The Conferences Series on Aging in the Americas is sponsored mainly by the U.S. National Institute on Aging and has addressed cross-national aging issues for the past ten years in seven conferences intended to develop a comparative framework for investigating the sustainability of health and support systems in the two nations (Zeki Al Hazzouri et al. 2011; Knaul et al. 2007; Salinas et al. 2013; Vega and Mudrazija 2015).

On September 17-18, 2015 the National Institute of Geriatrics of the Mexican National Institutes of Health (INGER) sponsored an eighth bi-national conference in Mexico City entitled "The International Workshop on Formal and Informal Systems of Support for Older Adults in Mexico and the United States in the Context of Health and Welfare Reforms." This Workshop's objective was to identify the major challenges that the United States and Mexico face during the coming decades in adapting existing old-age support systems, and to suggest new approaches to the support and care of dependent older citizens. As part of the discussions, the conference investigated the potential complementary roles of governmental and non-governmental organizations in addressing the problem. It also emphasized a search for solutions in Mexican elders, older Mexican-Americans, and other Latin-Americans residing within the U.S. The ultimate goal of this bi-national dialogue was to pinpoint culturally, politically, and economically practical ways to build support and caregiving capacity for older people in the geographic areas of interest.

To frame the group deliberations, the organizers proposed a conceptual model that represents the institutional embeddedness of family eldercare (Fig. 1), emphasizing four major structural and institutional spheres. The central sphere encompasses the family and the local community. We place Non-Governmental Organizations (NGOs) and Faith-based Organizations (FBOs), as well as the local governmental agencies that provide resources for eldercare, in this sphere. The three outer circles depict higher levels of government regulation, financing, and political action. Municipal governments provide services at the level closest to the family and local community. The resources available within local jurisdictions depend in general, on what is provided by state and federal governments. Ultimately, the resources and capacities of all lower levels of government and the environment in which civil society organizations operates are determined by national old age welfare policy, which in Mexico is still to be defined (López-Ortega 2014).

After a series of expert presentations, five groups of workshop participants were assigned specific topical areas and given the task of identifying the major dimensions of the problems, assessing the possibilities as well as the barriers to change, and proposing general avenues for further research and action. The recommendations and findings of the discussion groups will inform the scientific program of the next (ninth) ICAA Meeting, to be held in fall 2016. The five groups identified specific challenges that both nations face in developing more effective old age policies. The number of specific suggestions produced was too large to present in detail here (available upon request). What follows is a synopsis of the discussions and summaries of the major recommendations that the groups provided.

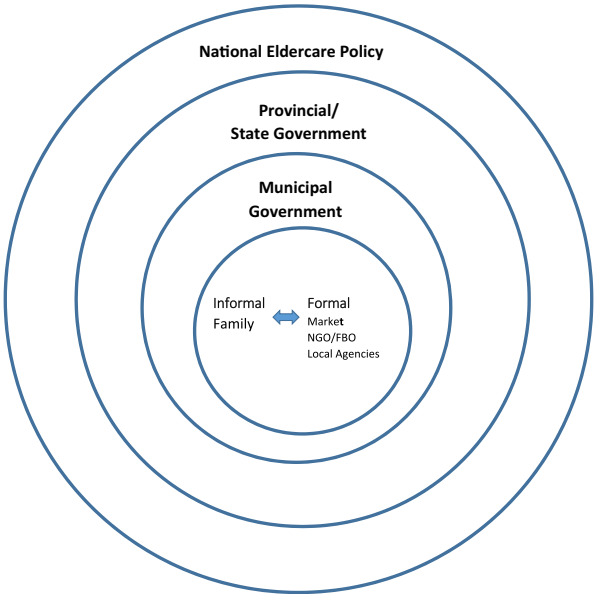

Fig. 1 Institutional embeddedness of family eldercare: formal and informal sources of support

Problems and Potential Solutions Identified by Conference Concensus Groups

The General Economic-Demographic Dilemma: Rapidly Aging Populations and Limited Resources

Mexico and the U.S. differ greatly in their reliance on families versus state, voluntary, community and private programs for caring for older persons. In the United States, the federal government provides Social Security retirement income and Medicare health benefits to nearly all citizens 65 and older. While these programs supply a substantial but incomplete amount of income security and health insurance for Americans, it is particularly important for Latinos who have less wealth and are less likely to have a private retirement plan than Anglos. For 52.6% of Latinos, Social Security represents over 90% of their total income (Social Security Administration 2012).

Medicare is also important for the American Latino population. Despite high rates of chronic medical conditions, Latinos on average live as long as or longer than non-Hispanic white Americans (Markides and Eschbach 2005). Relatively low levels of wealth combined with longer periods of functional incapacity pose challenges to families as well as policy makers in states with large Latino populations. (Vega and González 2012). This issue may be magnified because many undocumented Latinos may receive no benefits at all. Even with Medicare, coverage gaps among the elderly remain. Medicare pays only 80% of hospital costs, and it does not cover long-term care. Medicare Part B, which covers physician and other services, requires co-payments, often covered by private "Medigap" insurance plans purchased by middle-class American elders. For low-income older Hispanics who cannot afford a Medigap policy, Medicaid can pay for some of these extra costs, but eligibility is varied and limited (Angel and Angel 2015). For professional long-term care in America, Medicaid is the major government funding source (Wallace 2012).

Without a specialized, professional long-term care system, the Mexican family is the primary source of economic and instrumental support for older adults. Already, the economic burden of care is significant. In 2013 out of the 5.7% of the gross domestic product (GDP) spent on health, uncompensated care accounted for 20.5% of the total, while the public and private sectors accounted for 40.7% and 38.8% of the total respectively. The amount spent on uncompensated care was almost equivalent to the amount spent on hospital services (21.3% of total health expenditure) and was higher than expenditures on primary care (16.5%) and more than double the expenditures for medications and other medical necessities (10.2%) (National Institute of Statistics and Geography 2015).

In Mexico, employment-based pension coverage remains low. In 2013 only 26.1% of adults 60 years and older received a pension (National Institute of Statistics and Geography 2014). This fact led certain local and state governments to offer non-contributory social pensions, and in 2012 the federal government introduced *Setenta y mas* (seventy and older), which originally covered poor elders in small rural areas. The program was expanded during the current Peña administration and has become universal for individuals over 65 years who receive no other pension. Although coverage has greatly expanded, the pension amounts are low. In 2014, this "Pensión para Adultos Mayores" program, administered by the Mexican Secretariat of Social Development (SEDESOL), provided a monthly pension of 525 pesos ($40) to approximately six million recipients (Bravo et al. 2015). Despite this benefit, almost one-half of Mexican elders live in poverty and many continue to work after age 65.

While the family has historically been the primary source of caregiving in both nations, reductions in family size, increasing life spans and other evolutionary demographic changes, may make this no longer the case. General pension income must be used for necessities such as food, clothing and shelter. With few caregiver support programs and a lack of affordable professional long-term care in both Mexico and the U.S., caregivers, who are mostly women, have to reduce hours of work or leave their jobs altogether to care for aging parents, generating labor instability and reduced pension contributions, among other problems (Lucke et al. 2013). These trends will result in a reduction in the proportion of elderly who are able to turn to their children for basic care needs. In the United States today, children often move far from their parents' homes (Golant 2011). In Mexico, migration from rural areas to large cities and the migration of younger Mexicans to the United States mean that communities are changing rapidly and the young are not available to care for the old (Montes de Oca et al. 2008). These changes imply that the future support and caregiving needs of Latinos and others in both countries may not be easily addressed through traditional family and community solutions.

Recommendation In both countries, the existing eldercare infrastructure consists of federal and state support for local community agencies that provide long term care. The support and care of dependent elderly individuals cannot be adequately addressed at the community or familial level. Both federal governments must take a leading role in eldercare policy and service provision. The utilization of public health agencies to facilitate caregiving is part of a model of responsibility that includes governments, communities, NGOs and families working together to deliver appropriate care (see Fig. 1 Institutional Embeddedness) (Lynn and Montgomery 2015). Greater linkages between community and family long-term care services and the formal health care system are also important to improve efficiency in care quality and delivery.

Until federal policy incorporates elder care into municipal public health organizations a number of issues must be resolved. First, articulation of services provided by public health

departments must be achieved. These agencies must be convinced to expand their services and receive the funding to do so (Wallace and Gutiérrez 2005). Eldercare policy must adapt to changes in family and household composition and dynamics. Governments will have to provide assistance to community caregivers with child care options and other policy supports.

Limited Sources of Informal Care Available in Both Countries

In addition to the private sources of long-term care, the United States employs a patchwork of public assistance programs at the community level. (Montgomery 2015). Income assistance programs vary by local area and county-level human service agencies. Government-sponsored Area Agencies on Aging, federal but non-Medicaid-funded home and community-based care programs, administer the Older American's Act National Family Caregiver Support Program (NFCSP), enacted in 2002. This program provides training to informal caregivers caring for dependent family members in the community, as well as respite services, adult day care, and hospice (Reinhard et al. 2011). The Aging and Disability Resource Center (ADRC) provides information and referral services. This program has proven invaluable in areas where no traditional respite providers are available. Despite the existence of these programs, minority families, and particularly Mexican-origin elders and their caregivers, tend not to use formal services and other supporting agencies and organizations (Aranda and Knight 1997; Herrera et al. 2012). Changing family traditions, however, may increase their use (Silverstein and Wang 2015).

Mexico is attempting to avoid what they consider to be the insurmountable burdens of U.S. old age welfare policy by continuing to emphasize reliance on the family for long-term care (Wong and Espinoza 2007). But the economic burden of informal care is significant, as noted above (National Institute of Statistics and Geography 2015). In the absence of family and community long-term care networks, the elderly would simply be without this support since no formal eldercare system of care exists. (De Vos 2000).

There are many informal health care programs in both countries, including NGOs and FBOs. These organizations hold the promise of experimenting with new ways of providing eldercare. They take on additional importance as governments are simply unable to provide all of the support and care that rapidly aging populations require. Informal (volunteer) health care programs operate in both countries, but in general they are more common in the U.S. than Mexico because of resource differences. There, general types of informal initiatives include self-care training programs, whereas the community programs are more ad hoc, and many are technology-driven.

In Mexico, the government has introduced voluntary programs such as IMSS: Oportunidades, now called IMSS-Prospera, to help the elderly poor, among other groups at risk of marginalization, to help participants stay healthy and improve their quality of life. This initiative consists of "promotores de acción comunitaria" (community action workers).and "técnicos de promoción y educación para la salud" (community health workers who are members of the immediate communities and are trained and paid by IMSS personnel) to educate their families and neighbors about strategies to foster healthful aging, including how to prevent and manage chronic disease, such as diabetes (Levy 2007). *Promotores* also link Latino communities along the border to the U.S. health care system (Rosenthal et al. 2010). These programs are one example of how local individuals and organizations can be used to provide direct contact with older individuals and their families.

Since 2004, Seguro Popular ("*Health Coverage for All*") has offered health insurance to the poor in Mexico (Knaul et al. 2007). The program has achieved nearly universal insurance coverage (The World Bank 2005). However, access, quality and use of services varies by region, ethnicity, and socio-economic characteristics. At the local level, the government of the Federal District, with support from the Economic Commission for Latin America and the Caribbean, launched a caregiving program in 2015 that trains health care professionals to supervise and support caregivers and family members who care for older adults (Amieva Gálvez 2015).

To be sure, there is tremendous variation in both formal and informal long-term care between the larger cities in Mexico and the vast expanse of less populated rural areas, and this is also true for access to regular medical care, the quality of that care, and the responsiveness to ethnic, language and cultural variation (Gutiérrez-Robledo 2002). Important disparities between rural and urban areas in the U.S. also exist, of course, but there are more resources available in the U.S. in and for rural areas, and in many instances, there are specific government programs to address the needs of specific cultural groups.

Recommendations

Both countries can benefit from a greater use of informal care as long as these programs are adequately funded, evaluated and regulated appropriately. Health consequences, trade-offs and adverse effects must also be understood. Technology-assisted programs, such as telemedicine, have promise, but they will require considerable investment and implementation and evaluation research to be proven. Other technological applications are possible. In developing countries, for example, it may be possible to identify specifically needy populations using mobile phone meta-data (Blumenstock et al. 2015). Specific policies and programs are needed to address the gender, race/Hispanic ethnicity, and rural/urban health care and informal care disparities. Research is also needed to determine the social factors that determine the quality of care that older adults receive through community-based, long-term care programs. In Mexico, the State must assume a stronger role to guide, regulate, evaluate institutional innovations within the public, private and voluntary sectors, and to provide human and economic resources for long-term care, with special efforts to support caregivers.

An important goal for both nations should be to create new care strategies such as respite support, including the expansion of government-funded day-care centers for older adults. This is fundamental to improving the health and wellbeing of older adults, as well as their family members and other informal care givers.

While Mexico and U.S. face similar sets of issues in caring for dependent elderly, the differing familial, community, and economic contexts necessitate divergent solutions. One promising approach is to target long-term care services at the national level. It is critical to advocate national/federal legislation that promotes the use of public health organizations to educate and empower communities and families to deliver quality care.

The Potential Utility of NGOs and FBOs

As both countries age, traditional non-governmental organizations (NGOs) and faith-based organizations (FBOs) either have been advocating for the old, or are redefining their missions to include vulnerable older individuals (Valdés Olmedo 2006). Although we are aware of the efforts of major NGOs in eldercare in many parts of the world, the role of local NGOs and FBOs in caring for ill and disabled older persons in Mexico and the United States is

less understood. The potential of such non-governmental sources of care is significant and should be investigated. While federal and state governments control major economic resources, local organizations possess social capital and are in daily contact with members of their community. They are potentially in a position to supplement governmental agency efforts in caring for frail older members of the community. In the U.S., the federal government allows faith-based institutions to receive funding for community improvement projects. Given their social importance, the potential role of NGOs and FBOs in improving the lives of older impoverished citizens and their families deserves serious attention.

In regions where stable government support for long term care, within both Mexico and the U.S., NGOs and FBOs are immediate providers of assistance to the frail elderly. These organizations provide care and support to marginalized populations, including the poor, indigenous populations, and individuals suffering from common and severe diseases, such as AIDS. In addition to providing services, these organizations often advocate politically for the populations they serve. An example in the U.S. is the American Association of Retired Persons (AARP), a non-profit advocacy organization with over 30 million members 50 years and older. Given that community-based care is poorly supported in both countries, political advocacy appears to be a necessity.

FBOs could have an important role in the delivery of health and long-term care services to populations in need in the USA and Mexico. However, as noted in the conference presentations, there are strengths and weaknesses of such programs. Strengths include close ties to various ethnic groups and provision of services at little or no cost. Weaknesses may include inadequate resources, proselytizing, lack of care quality oversight, attention to only certain religious groups, and lack of coordination with other publicly provided health care.

Despite the promise of elder care from NGOs and FBOs, there are inadequate data for both the U.S. and Mexico to determine the types, reach, roles efficacy and stability of these organizations in delivering health services to older people. Some surveys and inventories have been done in both countries, but the sampling coverage was deemed incomplete. For example, in Mexico some public institutions such as INAPAM (National Institute for Older Persons) and DIF (National System for the Development of Families) report certain information on the ten long-term care facilities they have in the country, the information is limited to the type of services provided. No evaluations on the care provided or health outcomes of the residents have been systematically published.

On the other hand, the rapid increase in the number of residences known as “asilos” or “casas de reposo,” that operate as NGOs has increased from 525 in 2005 to 837 in 2015 (Rodríguez Dorantes 2015). Research is needed to provide a clear picture of the role that NGOs play in elder care (López-Ortega and Jiménez 2014).

Recommendations

FBOs and NGOs should be encouraged in communities where help is needed. However, as noted, they should be monitored for quality assurance, provision of equal access, and continuity of care, just as all other community-based services should. In addition, all NGO/FBO health care programs should have ongoing formal evaluation for the characteristics noted above, both during early implementation and as the programs mature, so that overall value and comparative effectiveness can be judged. Furthermore, given the gap in our knowledge on long-term care institutions and their care models in Mexico, all social actors, whether formal, informal, or community-based, need to be identified, along with the target population and the

services they provide. Mexico needs to position aging and its health and social challenges as an important part of the public agenda. Further, it is critical to characterize the amount and types of care offered, the quality of that care, sources of funding, estimated institutional longevity and the unmet needs of special populations such as elders with serious cognitive impairment and physical disabilities.

Inadequate Governmental Institutions: Programmatic Evaluation of Eldercare Provided by NGOs and FBOs

Program general health goals are inadequately evaluated, including health outcomes, economic efficiencies and interactions with government programs. Thus, enforcing standards and monitoring of informal health care systems is essential. Even so, in general, there are many sets of standards for health care programs in both the U.S. and Mexico. In Mexico, the lack of a national, state and local compulsory registration system for long-term care institutions implies that disaggregated data from various sources must be consulted, making it complicated to have a precise knowledge of long-term care institutions that can be held accountable. While the current legal framework related to health and social care is extensive, it does not enhance or regulate the full scope of long-term care and there is no evidence of the enforcement and monitoring of such standards. While the lack of standards and monitoring for informal care programs may make it more difficult to develop and maintain in many instances they are needed.

Recommendations

For informal care programs, including those conducted by NGOs and FBOs, with a potentially large population impact and the ability to address important needs, general standards and monitoring for such issues as quality of care and protection from adverse effects should be periodically conducted. This does not argue against diverse and innovative approaches to informal care delivery, but only for general assurances of appropriateness.

Conclusions

Given the fiscal realities of increasing expenditures for elder support and care, population aging creates new demographic and social realities in both Mexico and the U.S. that require innovative approaches, as well as crafting public policies that increase the use of non-governmental organizations to provide ancillary and support services that the State cannot. Challenges in Mexico arise from a current restricted fiscal capacity and increasing public costs because population age structure changes and an epidemiological transition to chronic and degenerative diseases that have to be tackled in parallel with persisting infectious diseases. However, a recent study of long-range fiscal projections of spending shows that under an "aging-only" scenario, and no change in the age profile of expenditures, the fiscal impact of population aging in Mexico would be mildly beneficial, accounting for 1 or 2 percentage points of GDP over the next 40 years. This is explained not by demographic changes, but by reforms in the contributory pension systems to PAYGO schemes that have shifted and will shift some pension costs away from public budgets. Also, there is already an institutional base that, in addition to existing national and state legislation, can be used to further advance aging

and old age issues in the public agenda and translate these into national public policies (Vivaldo Martínez and Martínez Maldonado 2014).

In the United States, currently low levels of institutional care use and projected demographic changes among Latino families suggest that in the future, families will need and demand more and better community-based long term care services (Vega and González 2012). These and other issues related to eldercare and public policy will inform future installments of the International Conference on Aging in the Americas (ICAA). For information on the conference series see the conference website hosted at The University of Texas at Austin. http://lbjschool.austin.utexas.edu/caa/.

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